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Trends

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Public Policy

Interview:

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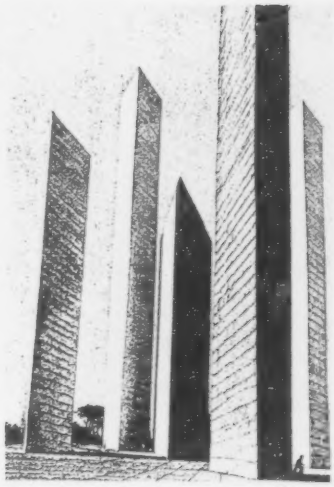

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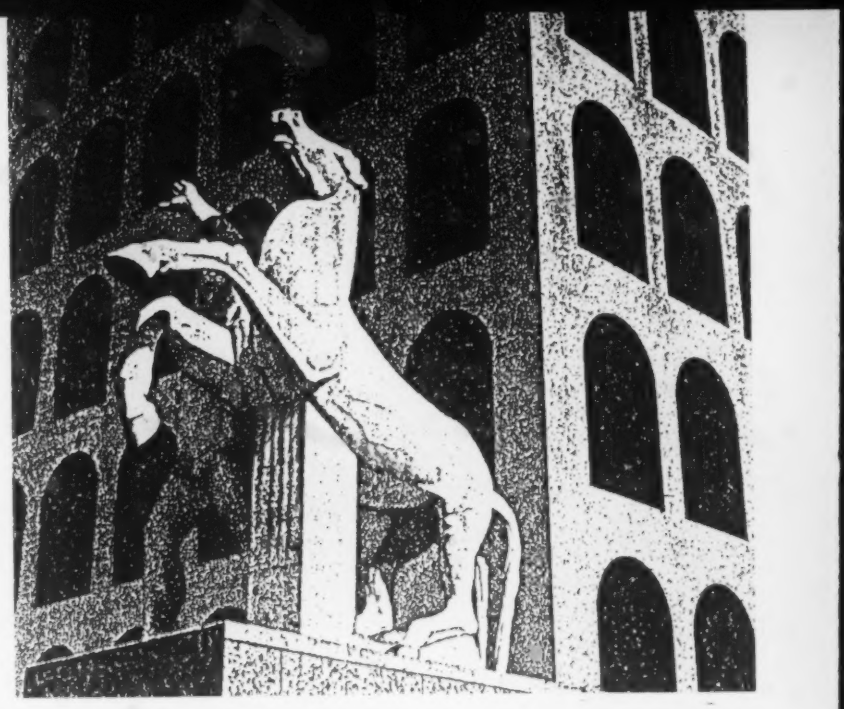
Health Care Under Siege:

Challenge for Change



Patricia L. Starck

Health care in the United States is dominated by fee-for-service payment to doctors, third-party payers motivated to conserve their funds, and consumers who are largely unaware of costs (Enthoven & Kronick, 1989a). There is little or no incentive to find more economical means to achieve health outcomes.

Ethical indictments. In our progressive nation, which prides itself on its ingenuity, health care costs and quality remain enigmas. Serious ethical indictments of our way of providing health care are replete in the literature. The following ten indictments characterize our present state of affairs:

1. Citizens do not enjoy a basic right to health care: 37 million U.S. citizens do not have health insurance of any kind (Health Insurance Association of America (HIAA), 1989).

2. Our present system of financing health care is inflationary, unfair, and wasteful (Enthoven & Kronick, 1989a).

3. The U.S. health care economy is a paradox of excesses and deprivation (Enthoven & Kronick, 1989a).

4. The present system is characterized by intergenerational (Callahan, 1987) and socioeconomic inequities.

5. Rationing is both pervasive and irrational, based on who can pay (Frech, 1988).

6. There is a bias toward acute care medicine and high technology even without scientific evidence of superior results.

7. Prevention, health promotion, and long-term care are woefully inadequate.

8. Whereas in most industries technology promises a better product at a lower price, health care technology is responsible for runaway costs (Frech, 1988).

9. In spite of increasing costs of hospitalization, hospitals are closing at an astonishing rate. It is predicted that 40% of existing hospitals will close or convert to another purpose by the year 2000 because of financial failure (HIAA, 1989).

10. Health insurers want to insure those persons who are least likely to need medical care, and to protect themselves and their policy holders from covering the costs of the very sick (Enthoven & Kronick, 1989a).

The problems of macroallocation. At the macrolevel, the question is, "How much of the national budget should be spent on health care?" Americans have not asked that question; rather, the costs are totaled at the end of each year, and each year the costs continue to climb. In the United States, approximately $1.5 billion per day is spent on health care (HIAA, 1989).

The percentage of the gross national product (GNP) spent on health care has been steadily rising over the past several decades, from 4.4% in 1950 to 11.2% in 1987 (HIAA, 1989). It is projected to grow to 15% by the year 2000 (Enthoven & Kronick, 1989a).

A significant portion of the GNP (3%) is spent on the elderly, and 1% of the GNP is spent during the last year of life (Callahan, 1987). Of the total GNP spent on health care, 40% is spent on hospital care (HIAA, 1989). The United States spends more on health care than any other developed nation (see Table 1). In 1986, Japan and the United Kingdom spent approximately one-half the U.S. amount.

Furthermore, the amount spent does not seem to increase overall life expectancy. Life expectancy for Japanese males in 1986 was 75.9 years compared to 71.4 years for U.S. males.

The macroallocation process is failing to provide health care for all citizens at even the minimum level. In 1989, the 37 million uninsured Americans amounted to 17.5% of the U.S. population, excluding those over 65 years who are covered by Medicare (HIAA, 1989). Moreover, nearly 50% of the uninsured are working, usually at minimum wage. Of the remainder, 33% are children and 17% are unemployed (HIAA, 1989).

Who pays the bills for health care? In 1987, health care was financed by 41% public spending and 58.6% private spending.

Of the total GNP, 40% is spent on hospital care; yet U.S. hospitals are having serious financial troubles.

Patricia L. Starck is professor and dean, School of Nursing at the University of Texas Health Science Center at Houston. This article is adapted from a convocation speech at Georgia Southwestern College, Americus, Georgia, October 25, 1989.

National health care: It ought to be a plan, not an accident. Starck compares how it is with how it ought to be. She assesses the predominant problems of AIDS, elder care, and organ transplant. She also makes a case for national health planning. *Key Words: health care policy, costs, economics, ethics, access to care, elderly, AIDS, organ transplant, rationing*

Despite the growth of hospital expenditures at a much faster rate than the GNP, the number of hospitals has risen only as fast as the population. In 1950, the average cost of a hospital room was $16 a day; in 1975 it was $152 (Frech, 1988). In 1987, the U.S. average cost in a community hospital was $538.96 per day (HIAA, 1989). Even so, hospitals are going broke. Hospitals have come under increasing financial pressure and thus are developing strategies to avoid caring for those who cannot pay, such as closing emergency rooms (Enthoven & Kronick, 1989a).

Microallocation. Presently, no predeterminations have been made for how much should be spent for acute care, chronic care, prevention, health promotion, or rehabilitation. No decisions have been made on how much to spend for the rising incidence of cancer, nor for the decreasing incidence of cardiovascular disease. There are no goals for expenditures for infants, youngsters, adults, and the elderly. The cost effectiveness of technology has not been adequately analyzed. At the microlevel, there are many areas of runaway costs. This article will examine three:

1. Persons needing transplants.
2. Persons with Autoimmune Deficiency Syndrome (PWA).
3. Elderly persons needing care.

Transplants. Transplant technology in this nation is unsurpassed. The human body has 27 donable organs and tissues. There is a shortage of donors: one third to one-half of patients needing transplants die while waiting. There are four times as many people needing kidneys as there are available kidneys. At the Texas Medical Center (TMC), there are over 200 patients at any given time waiting for a transplant. Only 10%–14% of the estimated 23,000 brain deaths per year result in organ donations. Table 2 shows four types of transplants, the number of them performed in 1988, the survival rate (defined in terms of one year after transplant), and the costs.

In the field of organ transplants, there is an ethical supply and demand problem. Organs are rationed on the ability to pay; patients must pass the "green screen." There is competition between foreigners and U.S. citizens for organs. Many wealthy foreigners come with cash in hand. Since the voluntary approach to organ donation has failed to provide the number needed, "required request" legislation has been considered to allow harvesting of organs unless denied (Coolican, 1986).

PWAs. There is a growing fear that the financial burden of caring for Persons with Autoimmune Deficiency Syndrome (PWAs) will become overwhelming and compromise other services needed by the public. Medicaid is assuming a heavy share of the burden to pay as PWAs are denied insurance or lose their jobs. Medicaid's budget is currently expending 25%–40% on PWAs. In 1986, Medicaid spent $2.3 billion on PWAs; in 1991, it is projected to spend $47 billion (Scitovsky, 1988). In February, 1989, there were 87,300 cases of Autoimmune Deficiency Syndrome (AIDS) and 49,976 deaths attributed to AIDS (HIAA, 1989). Furthermore, the Center for Disease Control predicts that in 1992, the number of new PWAs will exceed the cumulative total diagnosed from its inception through 1988. The 1992 total is expected to be 172,000 (Center for Disease Control (CDC), 1988). It is estimated that 1.5 million Americans are already infected.

New York is currently the city with the most Human Immunodeficiency Virus (HIV) infected persons. AIDS is now the leading cause of death among men 25–44 and women among the ages 25–34. Fifty percent (50%) of the IV drug users in New York are HIV positive and 400,000–500,000 New Yorkers have been infected. In 1987, 4000 AIDS patients took up 5% of the acute care hospital beds. This number is estimated to climb to 25%–40% of all acute care beds by 1991 (Weinberg & Murray, 1987). The AIDS babies are often "warehoused" in hospitals at the rate of $1000 per day in neonatal special care units (Meintz & Lynch, 1989).

The Elderly

In 1985, for the first time in U.S. history, the number of persons over the age of 65 exceeded those under the age of 18 (Callahan, 1987). The aging of the "baby boomers" in the next few decades will further strain the health care system. Between 1980 and 2000, the population is expected to grow by 18%, but the functionally dependent will grow by 38% to 15 million (Aiken, 1989). Projections by the agency Health Care Financing Administration (HCFA) are that by the year 2050, there will be 69 million people over the age of 65 eligible for Medicare, of which 15 million will be 85 or older (Rech, 1988). People over age 85 make up the fastest growing age group. Currently comprising 1% of the population, they are projected to make up 5% by 2050 (Callahan, 1987).

In 1985, the elderly comprised 11% of the U.S. population and accounted for 29% of the health care expenditures. In 2040, Callahan (1987) predicts, the elderly will comprise 29% of the population and account for 45% of the health care expenditures.

Callahan (1987) expressed his view that intergenerational equity is an economic and social issue. Problems include the large amount of health care spent on the elderly, the disproportional amount spent during the final phase when death is eminent, and the expenditures of research and development of technology for the elderly. Callahan stirred much controversy in his position of setting

limits for elderly health care, promoting a natural life span and a tolerable death. Fries (1983) specified the goal as a compression of morbidity, i.e., to promote health throughout life and delay or compress the disease onset until the very end of life.

Private insurance is still in its infancy. . .

An example of technology re-directed to the elderly is the end-stage renal disease program, which was originally intended to provide life-saving care to young people and working age adults in the prime of their productive lives. Five years after it was instituted, more than 20% of recipients were the retired and elderly (Rettig, 1980).

In the United States, there is no age limit for recipients; however, in the United Kingdom the limit is age 55 years for government coverage. In 1984, end-stage renal disease programs cost $2.1 billion in the United States. In 1974 there were 16,000 beneficiaries; in 1984 the rate had grown to 87,000 beneficiaries (HIAA, 1989).

Another high cost of health care for the elderly is institutional care. U.S. nursing home expenditures for 1987 totaled $40.6 billion (HIAA, 1989). The burden of this cost rests with two main sources—the patient and family and state taxpayers who fund the Medicaid program.

Private insurance is still in its infancy... (Frech, 1988). By the year 2000 these expenditures are expected to increase by 47% from 1987 levels (Callahan, 1987).

Ethical and economic solutions

This section focuses on principles of ethics and the goals of an ideal health care system. Economic considerations are presented in three models.

Ethical considerations.

Ethics, as a branch of philosophy, is an applied science. The science of ethics continually evolves as new and ever more difficult situations arise. However, ethical principles remain constant. The three basic principles of ethics focus on:

1. Beneficence. The production of good and prevention of harm. The continuum of good to harm allows for some risk. The risk is known as "informed consent." The principle of beneficence asks "Is it good? Is it more good than harm?"
2. Justice. The fairness of the distribution. Is it just? Is it fair? Who can live when not all can live? Are people treated equally?
3. Self-determination. The right to choose one's course of action. Is it respectful of human rights? Freedom of choice is a very strong American value.

There are two basic approaches to ethics: rule ethics and situation ethics.

1. Rule or deontological. The standard of right and wrong is the rule or law: "We must always tell the truth, keep our promises, etc." Decisions should be made according to the rule, not the goodness or badness of its consequences.
2. Situational or teleological. The purpose or meaning is important. The most well-known type of teleological ethicist is the utilitarian who seeks the greatest good for the greatest number. This approach is sometimes referred to as the "ends justify the means." Another type of situational ethics emphasizes love or *agape* within the situation (Fletcher, 1954, 1966, 1967, 1979).

Within this nation we have no clear ethical system. We sometimes abide by the rules; other times, we decide according to the situation at hand.

Engelhardt (1986), a medical ethicist at Baylor College of Medicine and Rice University, identified four goals of a just health care system (however, he found it an almost impossible challenge to design a system to meet all four goals).

These goals are:

1. The provision of the best possible care for all.
2. The provision of equal care for all.
3. Freedom of choice on the part of health care provider, and consumer.
4. Containment of costs.

Problems with an ideal system.

The problem with the goals of an ideal system is that there is a conflict between justice and equality. The resources one could use to aid those in need are often already owned by other people. Individuals in a free society have a right to private property. The government cannot force the selling of wedding rings in order to feed the hungry. In a free society, citizens can choose to give their money to feed Odie, the sperm whale, instead of feeding the poor.

Engelhardt (1986) identifies the concepts of natural and social lotteries as part of the dilemma. The natural lottery is the change in an individual's fortune that is the result of natural forces such as "good genes."

The natural lottery creates inequality and disadvantages for some without creating an obligation on the part of others. In the social lottery, some accumulate wealth, and some grow poor. If people lose at the natural lottery but win at the social lottery, they can purchase health care for their problems. The ones who lose at both the natural and social lotteries are presently those who fall between the cracks in the existing health care system.

Engelhardt (1986) uses the teleological approach to fairness in delineating the unfortunate from the unfair events. It is "unfair" when injuries and diseases are due to the action of others without the consent of the victims. Lawsuits usually follow to fix blame and exact compensation.

Table 1
Comparison of Percent GNP on Health Care, 1986

U.S.	11.7%
Sweden	9.1%
Canada	8.5%
Netherlands	8.3%
Germany	8.1%
Switzerland	8.0%
Japan	6.7%
United Kingdom	6.2%

Source: Health Insurance Association of American, 1989

In a free society, all needs cannot be translated into claims against the resources of others. Needs, much less desires, do not create rights to the services or goods of others. It is not like feeding the hungry and providing shelter to the homeless because it only takes a limited amount of food and shelter. An infinite amount of resources can be committed to the

preservation of life.

Neither can everyone be allocated an equal amount of money for their health expenses: Some would have too much, other would have too little. Therefore, Engelhardt (1986) concludes that humans are destined to live lives of unequal scope and fulfillment due to: (1) the natural and social lotteries, (2) private entitlements, and (3) free choice.

However, Engelhardt (1986) recognized that societies need health care systems to "blunt the outcome of the blind forces of nature through the rational planning of human beneficence." Health care systems help to insure against losses in the natural lottery; they relieve society to some extent of fears of disease, death, and deformity.

Table 2
Transplants: Numbers and Costs, 1988

Type	Number	Survival	Costs (in $1,000s)*
Heart	1,647	80%	150–200
Liver	1,680	65%	238
Kidney	9,123	96%	30 (same as 1 yr. of dialysis) Medicare pays 7
Pancreas	243	40%	40

* Plus $12,000 per year for immunosuppressant drugs.
Source: Organ Donor Center, 1989

Economical considerations.

There are three fundamental approaches to financing a health care system: free enterprise, a socialized system, or some modification of the two.

Free enterprise. A free-enterprise system relies on the market alone to effect supply and demand, to ensure quality and cost efficiency. However, health care is not a highly market-oriented industry for many reasons (Frech, 1988). Evans et al. (1989) concluded that the competition and the market place theme of the 1980s has been even less successful in containing the growth of health care expenditures than the regulatory attempts of the 1970s. A system that relies on the market alone will not provide a social safety net for those who lose in the natural and social lotteries.

Socialized system. A socialized system purports to provide equal care for all at public expense. This mode, often referred to as "socialized medicine," has universal access or equal care. Costs could be controlled based on a governmental system. No one could purchase extra care, although this would probably result in a black market.

Many countries have what is referred to as "socialized health care," and there are various opinions about its effectiveness and efficiency. Canada has had nearly 20 years of experience with its system of universal comprehensive coverage with substantially lower expenditures than those in the United States. In 1987, Canada's share of the GNP spent on health care was 8.6%, where it stabilized (Evans et al., 1989), which can be compared to the United States rate of 11.2%.

The difference in the United States and the Canadian systems lies in three areas (Evans et al., 1989):

1. Insurance overhead. The costs of running the U.S. payment system (costs of prepayment and administration) in 1985 was $95 out of $1,710 per person. In contrast, Canada spent $21 (Canadian dollars). The United States spends $26 per capita for administration of Medicare and Medicaid alone.
2. Payments to hospitals. In Canada, the motivation is to keep hospital beds empty; in the United States it is to keep them occupied.
3. Payments for physicians' services. In Canada, physicians are paid on a fee-for-service basis according to a fee schedule negotiated between each province and its medical association (Enthoven & Kronick, 1989b). In the United States there are fewer regulations to control fee-for-services.

In insurance overhead, savings occur from: estimating risk status, allocating shareholder profits, marketing expenses, collecting payment, determining coverage, eligibility, and benefits, handling claims, handling the flow of paperwork, and reimbursing the patient or provider.

Furthermore, the U.S. insurance system creates accounting costs for the provider to comply with requirements for documentation by different insurers, direct billing, and collections. It has been estimated that these provider costs amount to $21.4 billion per year (Evans et al., 1989). Canadian physicians do not have this overhead expense or the worry of uncollectible accounts.

Additional private insurance for hospital and medical care in Canada is prohibited for services included in the private plan. This prevents private firms from skimming off the good risks and having two classes of health care.

Modified combination. In essence, the United States now has a free enterprise system combined with socialized care. Medicare and Medicaid are funded at public expense as are the military health services.

In essence, the United States now has a free enterprise system combined with socialized care.

A well-designed proposal for a modified, combined approach to financing health care is known as the Consumer Choice Health Plan (CCHP) for the 1990s. Enthoven and Kronick (1989a, b) at the Graduate School of Business at Stanford University have developed an employment-based system for national health care. Their work has been supported by the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation.

The goals of the CCHP, which features "nearly universal coverage," are:

1. To provide financial protection for health care expenses to all.

2. To promote economical financing and delivery arrangements through cost-conscious consumer choice.

This proposal is designed using incremental change, based on the fact that most of our country's health coverage is based on employment.

In conclusion, the U.S. health care system is sick and rapidly running up intolerable bills.

Medicare and Medicaid would stay the same at first. The plan uses managed competition with mixed public, state-level, and private sponsorship. The care would be subsidized at the 80% level, with the individual paying 20% unless the individual is at 150% of the poverty level. Employers would be required to cover all full-time employees and their dependents who are not otherwise covered, and to finance this through an 8% payroll tax on the first $22,500 of wages and salaries. Self-employed persons, early retirees, and others not covered by full-time employment would be taxed 8% via income tax.

Consumers would choose among qualified health plans, both for profit and nonprofit, to include basic benefits. The intent is to encourage the development of cost-effective managed care plans.

The Congressional Budget Office has estimated the efforts of this proposal on coverage, costs, and public sector budgets. It is "budget neutral" and would not affect the federal deficit. The cost would be approximately $2,400 per family per year.

In a different approach, Engelhardt (1986) noted the advantages of establishing a Two-Tiered model. The first level would provide a decent minimum level of health care to everyone, rich and poor alike.

The second level would provide an option for additional care to be purchased by those who could afford it. Some might find objectionable the idea that the rich could purchase care not available to the poor. However, Engelhardt (1986) emphasized that there is a trickle-down benefit.

Engelhardt (1986) believes this approach meshes with U.S. values: The Two-Tiered model does not deny a place for U.S. ambition and for the desire to acquire material resources.

The Two-Tiered model allows for free choice, provides an equal basic level of care for all, and allows those with more resources to purchase additional care if they wish.

Comparison of the Canadian Plan, the Consumer Choice Health Plan, and the Two-Tiered model is made using Engelhardt's four goals of an ideal system.

No plan meets all four goals. The Canadian Plan meets the goal of best care within economic limits. It provides equal care and is cost conscious. However, choice is limited by certain constraints.

The CCHP meets the best of health care goal with equal coverage for all. It is designed to be cost conscious with a large share of costs being sustained by employers. However, choice on an individual consumer level may be limited because of managed care contracts.

The Two-Tiered model encourages continued research and development to maintain the goal of best care. It would provide a level of general care equally. Those who could afford it could have a choice within the second tier, but not within the first tier. It is cost-conscious from the standpoint of general care and depends on free enterprise for the second tier. Thus, no model is capable of perfectly satisfying all goals of an ideal health system.

Conclusion

In conclusion, the U.S. health care system is sick and rapidly running up intolerable bills. Projections are that it will get worse. As responsible citizens who have ethical concerns for fellow human beings as well as for future generations, Americans must face existing problems and make the tough decisions that are required. Ethics and economics are considerations in finding long-term solutions. While there may be no perfect model that fully meets the ideals of best care, equal care, free choice, and cost-consciousness, action is required to begin the trajectory of humane and cost effective health care for U.S. citizens.

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